maintains that the patients who suffer from tabes are cheerful, but other authors disagree with him, and claim that the mood is changeable; at times they are elated, but oftentimes they are markedly depressed, even suicidal, suffer with insomnia and become very nervous. However, in many cases no such symptoms develop except an ordinary hypochondria. Simon alleges that all tabetics present a peculiar mental symptom complex, which he termed "Tabetic Dementia." Further study of Simon's patients showed that the so-called tabetic dementias were nothing but ordinary cases of paresis. Nageotte studied three cases of tabes which were devoid of mental symptoms, but post-mortem examination disclosed a distinct pathological process corresponding to that found in general paralysis. In regard to the real psychosis in tabetics, Bornstein states that in almost all cases of tabes, hallucinations of all senses play an important rôle in the clinical picture. Kirsch and Pierret and their pupils regard such a psychosis typical of tabes. According to Pierret, the fundamental symptom in such a mental derangement is melancholia, which is founded on a somatic basis. From such a state, sensory disturbances become marked and exaggerated by patients. For instance, pain may be interpreted as an imaginary foe and reduction of vision gives rise to optical false perceptions. Nageotte, Moebius and others disagree with Pierret. But Moebius, however, admits that tabes dorsalis and paranoia may occur in the same individual. Otto Meyer has made a study of 56 undoubted cases of tabes with various mental aberrations. He groups his cases as follows: Paranoia (chronic hallucinatory), 21 times; depressive psychosis (melancholia and hypochondria), 14 times; circular psychosis, 4 times; acute hallucinatory confusion (amentia), 2 times; maniacal excitement, 1 time; secondary dementia (after paranoia), 1 time; paranoia dementia præcox (Kraepelin), 1 time; primary dementia, 3 times; psychosis with hallucinations of restless character, 3 times; severe periodical excitements, 1 time; excitement in defective mental development, 2 times; dementia præcox, 1 time.

Schultze described two cases of tabes, one of which was melancholic, and the other a paranoic. The usual ratio of tabes between men and women is 3 to 1; locomotor ataxia with psychosis, 1.6 to 1. This shows that the relative frequency of psychical disturbance in female tabetics is greater than in men. Functional insanity (but not paresis) is more common in those tabetics which show an affection of the optic nerve and the nerves which regulate the pupillary accommodation; and furthermore in those patients who have marked consanguineous vesanity. Bornstein describes a patient who developed a clinical picture of tabes with optic involvement, who was subject to several attacks of mental disturbance. The psychosis was essentially of an hallucinatory nature. The patient reacted to auditory, visual, haptic hallucinations, and was disoriented, excited, confused and irritable. These mental symptoms rapidly subsided and the patient regained his normal equilibrium without insight. The author's conclusions are briefly as follows: (1) There are no specific foundations for a tabetic psychosis. (2) The most important symptoms of all functional, mental disorders, occurring in tabes, are hallucinations of all senses. (3) The psychical disturbance in tabes should not be considered as a complication of this disease process. (4) The frequent psycopathic symptoms in tabes usually arise from distinct somatic disturbances, as, for example, optic atrophy, paresthesia and other sensory anomalies. (5) Patients without a predisposition for mental disorders may have hallucinations without a true psychosis. On the other hand, those patients who have a distinct vesanic taint may develop different forms of psychoses, such as paranoia or depression.

F. J. Conzelmann (New York).

The Neuritic Type of Progressive Muscular Atrophy. A Case with Marked Heredity. By Archibald Church (Chicago Medical Recorder, November, 1906).

The writer reports a case of the true peroneal type—extending through six, and probably eight, generations. According to the history the disease successively became more extensive and severe with each generation. The patient states that no females in the family were ever similarly affected, but two maternal aunts had optic atrophy, and a sister weakness of the ankles. J. E. CLARK (New York).

TRUE SCIATICA AND DISEASES OF THE POSTERIOR URETHRA AND ADNEXA. By G. S. Peterken (California State Journal of Medicine, August, 1906).

The author differentiates (1) sciatica neuritis, or true sciatica, the symptoms of which are those common to all inflamed nerves; (2) symptomatic or false sciatica, the symptom of which is pain in or along the sciatic nerve with absence of local objective symptoms usually accompanying neuritis. In the opinion of the writer, false sciatica is frequently due to a chronic inflammatory state of the posterior urethra and adnexa, and the thorough examination of the male sexual organs is advocated in all cases. J. E. CLARK (New York).

MIGRAINIC PSYCHOSES. Alfred Gordon (Journal A. M. A., Jan. 5, 1907).

The author reports twelve cases of migraine associated with mental symptoms, observed within the last four years, and all presenting similar types of derangement; namely, confusion, delirium, usually with hallucinations, and stupor. The hallucinations were usually visual, though gustatory and auditory hallucinations were also observed. The confusional stage predominated in all, and was frequently accompanied with illusions of identity, incoherence and disturbance of orientation. Some of the cases suggested psychic epilepsy or procursive epilepsy. In the majority of cases the mental symptoms occurred during the attacks, and in some they continued twenty-four hours after the subsidence of the migraine. In some cases, however, they occurred either before or after, and they lasted in some cases for twenty-four hours after the subsidence. He does not think that he can explain these conditions as epileptic or hysterical, though in some cases they suggested it. The special point is their association with an autotoxic condition, which is the basis of migraine.

LANDRY'S PARALYSIS. J. N. Hall and S. D. Hopkins (Journal A. M. A., Jan. 12, 1907).

The authors report on five cases of acute ascending paralysis, all fatal but one, and review and analyze other recent cases published, and discuss the condition generally They conclude that not one bacterial species can be credited with this intoxication, though there can be little doubt that it is due to bacterial products. There is no apparent occupational factor, though the predominance of the disease in males might suggest such a possibility. Their analysis of carefully reported modern cases would seem to show that sphincter involvement is more frequent than is stated in the text-books. As regards diagnosis, confusion is likely to arise with acute ascending myelitis, multiple neuritis and anterior poliomyelitis. In the former the sensory involvement, trophic disturbances, wasting of muscles and loss of faradic irritability should aid the diagnosis. In multiple neuritis the sphincters are not involved. The paralysis is usually limited to peripheral muscles, and there is marked pain, tenderness and sensory disturbance. Anterior poliomyelitis is a limited paralysis of the extremities, usually the lower extremities, with marked wasting, lacking sensory disorders and with tendency to rapid improvement. The treatment of Landry's paralysis is chiefly supportive. In the author's patient, who recovered, benefit seemed to be derived from salicylates and iodid of potash, followed later by strychnin, massage and electricity. Mercurial inunction was also applied, though there was no specific history.